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Nos. 93-1408, 93-1414, 93-1415

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IN THE

SUPREME COURT OF THE UNITED STATES

October Term, 1994

NEW YORK STATE CONFERENCE OF BLUE CROSS & BLUE SHIELD PLANS, *et al.*,
Petitioners

v.

TRAVELERS INSURANCE CO., *et al.*,
Respondents.

MARIO CUOMO, *et al.*,
Petitioners

v.

TRAVELERS INSURANCE CO., *et al.*,
Respondents.

HOSPITAL ASSOCIATION OF NEW YORK,
Petitioner

v.

TRAVELERS INSURANCE CO., *et al.*,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Second Circuit

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BRIEF OF THE GROUP HEALTH ASSOCIATION OF AMERICA, INC. AS *AMICUS CURIAE* IN SUPPORT OF RESPONDENTS

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BRIEF OF THE GROUP HEALTH ASSOCIATION OF AMERICA, INC. AS *AMICUS CURIAE* IN SUPPORT OF RESPONDENTS

This brief of Group Health Association of America, Inc. ("GHAA"), as *amicus curiae,* is filed in support of respondents and in favor of affirmance of the ruling of the United States Court of Appeals for the Second Circuit on the preemption questions presented under the Employee Retirement Income Security Act of 1974,

as amended ("ERISA"). GHAA submits this brief with the written consent of the parties, as provided in Rule 37.3 of the Rules of this Court.

INTEREST OF AMICUS CURIAE

The Group Health Association of America, Inc., founded in 1959, is the oldest and largest national association for health maintenance organizations ("HMOs"). GHAA has more than 375 HMO member plans nationwide. Together, these members enroll about 40 million people. More than 50 million Americans, one-fifth of the total population of the United States, receive their health care coverage through HMOs.

HMOs provide integrated, coordinated, high-quality health care coverage, with an emphasis on preventive care, at predictable and affordable costs to consumers. HMO members are highly satisfied, and HMOs have received high enrollment renewal rates. For these reasons, many employers, including multi-state employers, offer benefit plans using the HMO approach to health care delivery.

GHAA has a strong interest in the ERISA preemption questions presented by this case because permitting the states to regulate through laws that interfere with the design and structure of employee benefit plans offering HMO coverage would severely compromise the ability of HMO plans to maintain the cost efficiencies they have achieved. HMOs' ability to provide more affordable, comprehensive coverage and to limit out-of-pocket costs has significantly reduced the financial barriers to accessible health care that exist with other forms of health care coverage. This enables HMOs to emphasize a philosophy of prevention, which means that HMO members are able to seek care for small health problems before they become serious ones. If allowed to stand, the states' disparate economic treatment of HMOs will undermine the ability of employers, and ultimately their employees, to choose the HMO

approach – the most cost-efficient system of health care available today.

The State of New York, through the imposition of a 9% assessment on the cost of inpatient hospitalization services to HMO plans, has severely limited the efficiencies HMO plans have achieved through a comprehensive system of benefits and preventive care. The effect of the State's assessment is to disrupt the benefits of a high quality, cost-efficient HMO plan sought by employers with employees in New York. The Second Circuit's conclusion that New York's 9% assessment is preempted by ERISA because it "relates to" ERISA plans that select HMO coverage protects HMO plans from such interference by the states. It further ensures that employers who offer such plans will not be subject to a differing scheme of regulation across the states in which they have employees.

SUMMARY OF ARGUMENT

With increasing frequency, sponsors of employee health benefit plans are choosing to structure their plans around the cost competitiveness of HMOs, seeking the benefits of a high quality, coordinated care system both for the participants in the plan and the sponsors themselves. The HMO option provides employee benefit plans with quality health care coverage and comprehensive benefits at an affordable price.

In response to the historical obstacles to the development of HMOs imposed by the states, Congress established a federal policy, through the enactment of the Federal Health Maintenance Organization Act, to shield HMOs from unfair treatment. This federal law has provided HMOs with the necessary protection to develop and flourish without state interference.

The Federal HMO Act was enacted in 1973, one year before Congress passed ERISA, another federal law intended to protect employee benefit plans from state interference. ERISA's expansive preemption clause has

been interpreted by this Court to prevent the states from interfering with the operation and structure of ERISA health benefit plans and from disrupting the uniform federal regulation of such plans.

New York's 9% assessment singles out HMO plans for disparate economic treatment. The impact of the assessment on HMO plans is direct and substantial because it forces plans either to raise costs by a factor of up to 3.5% or to reduce benefit levels, or some combination of the two. Moreover, by singling out HMOs to the exclusion of other health care delivery systems, the 9% assessment disrupts the balance of incentives established when plan sponsors emphasize HMO coverage over more costly indemnity insurance. Such disruption intrudes upon the structure of ERISA benefit plans. ERISA prohibits such disruption to the design and administration of employee benefit plans by the states, particularly where, as here, the disruption is targeted at one particular form of health care delivery system.

In construing ERISA's preemption clause, this Court has turned to federal policy as a guide to Congress' intent in removing employee benefit plans from the realm of state regulation. Finding that the 9% assessment interferes with the choices made by employee benefit plans in providing health care coverage to their members is consistent with the purpose of the Federal HMO Act – to prevent the states, which traditionally have favored indemnity insurance, from singling out HMOs through disparate regulation.

For these reasons, the Second Circuit's decision finding that the 9% assessment is preempted because it "relates to" ERISA plans should be affirmed.

ARGUMENT

I. THE DEVELOPMENT AND GROWTH OF THE HMO CONCEPT OF COORDINATED CARE IN THE UNITED STATES.

A. THE HMO ALTERNATIVE AND THE FEDERAL POLICY PROTECTING IT.

Fifty years ago, the concept of prepaid health care coverage was a novelty. HMOs historically have faced difficulty in entering and competing in health care markets dominated by health plans and insurers operating on an indemnity basis and have struggled with the long-ingrained hostility to prepaid, closed-panel medical practice among segments of the medical community. *See, e.g., American Medical Ass'n v. United States,* 317 U.S. 519 (1943); *American Medical Ass'n,* 94 F.T.C. 701 (1979), *aff'd as modified,* 638 F.2d 443 (2d Cir. 1980), *aff'd per curiam,* 455 U.S. 676 (1982).

In 1973, Congress took steps to remove impediments to the development and growth of HMOs by enacting the Federal Health Maintenance Organization Act of 1973, 42 U.S.C. §§ 300e, *et seq.* (1987). Some of the Act's provisions created authorizations for appropriations for HMO feasibility, planning and development, and others barred the states from restricting HMO activities through legislation.

The Congressional findings that resulted in the HMO Act include "substantial evidence" to establish that HMOs provide high quality care to their members at a lower cost — as much as one-fourth to one-third lower than traditional care. S. Rep. No. 93-129, 93d Cong., 1st Sess., *reprinted in* 1973 U.S.C.C.A.N. 3033, 3034. Thus, in order to permit HMOs to continue their growth and development, and to continue to fill their niche in the national health care system, Congress enacted a federal law protecting HMOs from interference by the states:

> First, and most important, the development of HMOs throughout the country will provide consumers with the opportunity to choose the manner in which they will pay for and receive health care services. At the present time, no such choice exists in most parts of the United States. Therefore, in excess of 95% of all health services are rendered on a fee-for-service basis. The goal of this legislation is to increase the options from the point of view of the consumer.

Id., at 3039-40.

Since the enactment of ERISA, Congress has amended the Federal HMO Act several times. The amendments extended the authorizations for appropriations for HMO feasibility, planning and development, and provided HMOs flexibility in meeting consumer needs. In passing the 1978 amendments, Health Maintenance Organization Amendments of 1978, P.L. 95-559, 92 Stat. 2131 (codified as amended at 42 U.S.C. §§ 300e, *et seq.* (1987)), Congress expressly emphasized the important role played by the reforms generated by the HMO delivery system, particularly in terms of their cost efficiency:

> Few health care delivery reforms enjoy the deep support and broad appeal of the Health Maintenance Organization concept. One of the major advantages of HMOs is their cost containment potential. The skyrocketing cost of health care is one of the most pressing issues facing the nation today. While HMOs are not the final answer to the health care cost problem they do give providers strong incentives to reduce unnecessary expenditures; and they create much-needed competition for the health care dollar.

S. Rep. No. 95-837, 95th Cong., 2d Sess. 8, *reprinted* in 1978 U.S.C.C.A.N. 4925, 4942.[1]

The 1987 amendments provided greater flexibility in the way HMOs are organized and operated. Health Maintenance Organization Amendments of 1987, P.L. 100-517, 102 Stat. 2578 (codified as amended at 42 U.S.C. §§ 300e, *et seq.* (1987)). In enacting these amendments, Congress again emphasized the important role that HMO plans play in American health care delivery systems:

> The HMO law has proven to be one of our most important public health statutes. . . . The law has helped to develop hundreds of prepaid health care organizations that have changed the face of medical care in this country. *HMOs have successfully controlled health care costs and, by their very presence, forced other providers and insurers to become more efficient and less costly.*

S. Rep. No. 100-304, 100th Cong., 2d Sess. 8, *reprinted in* 1988 U.S.C.C.A.N. 3231, 3232 (emphasis added).

When the Federal HMO Act was passed, there were only 39 prepaid health care plans in existence in the

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1. As part of the 1978 amendments, Congress specifically acted to abrogate certain state practices that were designed to interfere with the operation of HMOs while simultaneously favoring indemnity insurance. Under then existing provisions of the law, HMOs were required to meet state certificate-of-need requirements relating to the provision of basic health services to members. However, state agencies were employing unobjective appraisals for HMOs' certificates because HMOs competed with indemnity insurers, which frequently were given objective appraisals or were not required to file certification-of-need applications at all. S. Rep. No. 95-837, 95th Cong., 2d Sess. 13, *reprinted in* 1978 U.S.C.C.A.N. 4925, 4947-48. In order to further HMOs' "exceptional capacity to serve the overall goals of the planning process when allowed to operate properly," Congress amended the Federal HMO Act to establish more objective certificate-of-need standards that would be subject to less interpretation and variation at the state level. 42 U.S.C. § 300e(b)(4), (5) (1987).

United States, serving approximately 3.5 million enrollees. A mere five years later, the number of prepaid health care plans had increased five-fold to 198 plans, serving 7.3 million enrollees in 37 states. Interstudy, *National HMO Census: June 30, 1983,* 38-39 (1984); U.S. Department of Health, Education and Welfare, Public Health Service, Office of Health Maintenance Organizations, *National HMO Census of Prepaid Plans,* 1 (1978). This dramatic increase in the number of HMOs and the consumers served is perhaps the best evidence that the Federal HMO Act has been effective in achieving Congress' goal of encouraging the growth and development of HMOs.

B. THE HMO TODAY.

The HMO industry has continued to grow tremendously. Over the past 14 years, the number of people cared for by HMOs has grown more than five-fold to 50.5 million, up from 9.1 million people in 1982. GHAA, *National Directory of HMOs,* 22 (1993); GHAA, *1994 HMO Performance Report,* 3 (1994). A large proportion of American employers offer HMO coverage, and their employees are selecting HMO coverage at an increasing rate. By year-end 1995, 56 million Americans are expected to have selected HMOs for their health care coverage. GHAA, *1994 HMO Performance Report,* 1 (1994).

HMOs provide or arrange for the provision of health care services to their members in various ways. Some employ staff physicians. Some contract with individual physicians as independent contractors. Others contract with medical group practices or with associations of individually practicing physicians. Some HMOs may use a combination of these methods. However, all HMOs, by whatever method adopted, provide or arrange for the provision of health care services to members through integrated networks of select health care providers.

HMOs offer comprehensive coverage, including preventive care, on a prepaid basis. In contrast, traditional indemnity health benefit plans generally indemnify policyholders only for designated, medically-necessary health care services without regard to the provider of those services.

Covered basic health services under an HMO plan generally include physician services and referral services to specialists, inpatient and outpatient hospitalization, emergency care, diagnostic laboratory and therapeutic radiologic services, inpatient and outpatient rehabilitation services, recuperative therapy services (e.g., physical, occupational and speech), outpatient mental health services, detoxification services and referrals for addiction and home health care. Most HMOs also provide coverage for prescription drugs. *See, e.g.*, 42 U.S.C. §§ 300e-1(1) (1987) (basic health services for federally qualified HMOs); *see also* GHAA, *HMO Industry Profile: 1994 Edition*, 3-7 (1994). HMOs also provide preventive care coverage, including immunizations, well-child care from birth, periodic health evaluations for adults, voluntary family planning services, infertility services and children's eye and ear examinations. *See, e.g.*, 42 U.S.C. § 300e-1(1)(H) (1987) (preventive health services for federally qualified HMOs). As a rule, HMOs cover more services than indemnity insurance plans, typically with no deductibles and with minimal, if any, co-payments.

HMO coverage also is more comprehensive than indemnity insurance coverage in financial terms. For example, HMOs impose no lifetime limits on benefit coverage, and they cover pre-existing conditions with no waiting period. 42 U.S.C. § 300e(b) (1987) (HMO basic health services must be provided without limitation as to time or cost). Indemnity insurance coverage, in contrast, typically has a lifetime cap of $1 million and imposes a waiting period for coverage of pre-existing conditions.

HMOs set high standards for quality assurance and consumer satisfaction. HMOs promote health care quality in many ways, including careful selection of providers based on professional qualifications and interest in working within a coordinated care system. GHAA's most recent survey revealed that 85% of all HMO physicians are board certified. According to the latest data from the American Medical Association, only 61% of practicing physicians nationwide are board certified. GHAA, *1994 HMO Performance Report,* 11-12 (1994).

In addition, HMOs have quality assurance and improvement programs that are not available through indemnity insurance. HMOs utilize state-of-the-art practice guidelines and standards developed by independent accreditation organizations (*e.g.,* National Committee for Quality Assurance), monitor quality-of-care indicators and outcomes, identify and pursue areas for necessary improvements and measure improvements in performance over time. HMOs make available to the physicians and medical professionals who participate in their networks information regarding member referrals to participating specialists and medical facilities. HMOs also provide participating physicians and medical professionals with practice standards and utilization management data to ensure that patients receive medically necessary and appropriate care. These programs and sources of information enable HMOs to provide the employer-sponsor of an HMO plan with quality, effective and efficient health care for their employees.

The explosive growth of HMO plans is due in large part to the fact that employers have experienced annual premium increases averaging 13.4% for traditional indemnity health plans in recent years. KPMG Peat Marwick, *Trends in Health Insurance: HMOs Experience Lower Rates of Increase than Other Plans,* 4 (1993). Faced with the untenable choices of reducing contributions to the cost of employee health coverage or imposing new coverage limitations, adding or raising deductibles and coinsurance, reducing the benefits covered or

eliminating health coverage altogether, plan sponsors understandably have turned to HMOs as a more affordable means of providing comprehensive health care coverage to their employees.

It is these unique characteristics of quality assurance, comprehensive benefits and affordability that distinguish HMO plans from other health care coverage options, including indemnity insurance. Moreover, as a result of these attributes, HMOs bring cost efficiency to the health care market. In 1992, the cost of traditional indemnity plans averaged $4,080 per employee, 23.2% more than the average cost of HMOs ($3,313 per employee). A. Foster Higgins, *Health Care Benefits Survey: Report 1 Medical Plans,* 12-13 (1992). This cost differential does not take into account the greater differential that would result if the indemnity plans offered the same comprehensive level of benefits that HMOs offer. *See* U.S. Department of Labor, Bureau of Labor Statistics, *Employee Benefits in Medium and Large Establishments, 1991,* Bulletin 2422, 38-39 (May 1993) (most indemnity plan participants face average annual deductibles of approximately $200 and coinsurance rates of 20% for all basic services).

Simply stated, HMOs are typically the best value for health care coverage. HMO coverage is especially attractive to a multi-state employer because such coverage offers comprehensive benefits to its employees while simultaneously ensuring the employer that its employees have a coordinated system of health care coverage which is subject to quality assurance review – often at the lowest priced option for health care coverage.

The HMO approach – comprehensive benefits, preventive care coverage, continuity of service and quality assurance, all of which result in significant cost savings – has elevated HMOs to a singularly unique status in America's health care coverage system.

II. ERISA PROHIBITS THE STATES FROM INTERFERING WITH EMPLOYEE HEALTH PLANS THROUGH REGULATION WHICH SINGLES OUT HMO PLANS FOR DISPARATE ECONOMIC TREATMENT.

In 1992, the State of New York imposed a 9% assessment on the cost of inpatient hospitalization paid by HMOs. The assessment bears no relation to the actual cost of services provided to HMO members; rather, it is assessed by the State on the aggregate monthly cost of inpatient hospitalization. With the exception of HMOs, no other type of carrier or provider of health care services in the State of New York must pay the 9% assessment. N.Y. Pub. Health Law §§ 2807-c(2)(a) through (e) (McKinney 1993).

The State adopted the 9% assessment for the primary purpose of encouraging HMOs to enroll Medicaid eligible recipients. The State acknowledges that the 9% assessment is intended as a direct economic penalty for those HMOs that fail to meet the State's target enrollment levels of Medicaid eligible recipients. JA 156. The secondary purpose of the assessment is to raise revenue for the State. Notably, the funds paid by HMOs under the 9% assessment are deposited in the State's general fund and are not specifically earmarked to provide health care coverage to the medically uninsured or underserved.

The 9% assessment interferes with the structure and interstate operation of ERISA health benefit plans that select HMO coverage, thereby establishing the requisite "connection with" such plans for purposes of triggering ERISA preemption. With limited exceptions, ERISA preempts any and all state laws that "relate to" employee benefit plans. 29 U.S.C. § 1144(a) (1985). The clear intent of ERISA's preemption clause, as recognized by this Court, is to

> ensure that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was

> to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government. Otherwise, the inefficiencies would work to the detriment of plan beneficiaries.

Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 134 (1990).[2] ERISA, therefore, preempts any state law that has a "'connection with or reference to'" ERISA plans. *Id.*, 498 U.S. at 139, *quoting Shaw*, 463 U.S. at 96-97.

The Second Circuit, in striking down New York's 9% assessment on HMOs, ruled that the assessment "relates to" ERISA plans because it "purposely interferes with the choices that ERISA plans make for health care coverage." *Travelers Ins. Co. v. Cuomo*, 14 F.3d 708, 719 (2d Cir. 1994). The court reasoned that the 9% assessment interferes with plan design by forcing ERISA plans either to increase the cost of benefits or to reduce the level of benefits available to participants. *Id.*, 14 F.3d at 720.

Other circuit courts have recognized that state legislation which increases the costs of health benefits coverage disrupts the structure of ERISA plans. *See, e.g., Arkansas Blue Cross and Blue Shield v. St. Mary's Hosp. Inc.*, 947 F.2d 1341, 1348 (8th Cir. 1991), *cert. denied*, ___ U.S. ___, 112 S. Ct. 2305 (1992) (state law affecting insurer's costs has impact on benefit structure); *cf. General Elec. Co. v. Department of Labor*, 891 F.2d 25, 29 (2d Cir. 1989), *cert. denied*, 496 U.S. 912 (1990)

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2. *See also Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 11 (1986) (state severance pay statute preempted to alleviate burden on employers' administration of benefit plans); *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85, 105 n.25(1983) (state disability law burdening administration of nationwide plan preempted); *Alessi v. Raybestos Manhattan, Inc.*, 451 U.S. 504, 524-25 (1981) (ERISA preempts state law prohibiting offset of workers' compensation payments against pension benefits because it would burden employer plans with conflicting regulatory schemes).

(state law regulating payment of benefits preempted because private parties, not states, control level of benefits).

The 9% assessment has a substantial impact on ERISA plans that select HMO coverage. As a direct result of the 9% assessment on the cost of inpatient hospital services, it is estimated that the cost of HMO coverage in New York has increased by a factor of up to 3.5%. JA-265. Because HMOs must maintain reserves for unexpected medical expenses, this increase in costs must be passed on to the ERISA plans that have selected HMO coverage. JA-262, 265-66. Thus, the 9% assessment, in reality, functions as an assessment on the ERISA plans themselves.

When faced with an increase in the costs of health care coverage, an HMO plan has two options: pay the increase or reduce benefit levels. To absorb the cost increase without reducing benefit levels, HMO plans must raise the premiums that employees pay and/or increase employee cost-sharing through higher co-payments or deductibles. However, the payment of higher premiums and the addition of greater cost-sharing provisions embody the precise afflictions that the plan sponsor sought to avoid by selecting HMO coverage over indemnity insurance. The other option, reducing benefit levels, is equally offensive insofar as it also involves a departure from the HMO concept of providing comprehensive benefits and preventive care coverage. Most significant, however, is the fact that either option has the same result – the ERISA plan is forced to modify its structure and way of doing business.

In the face of these facts, it is undisputed that the 9% assessment and its attendant cost increase to HMO plans affect the administration and design of ERISA health benefit plans that offer HMO coverage. Petitioners Mario M. Cuomo, *et al.*, acknowledge that "[t]he health care assessments may influence plan content or administration because they do not affect all payors equally. State regulation does not affect every aspect of

plan administration or benefits identically and, therefore, a wide range of state regulation may influence ERISA plan activity." Brief for Petitioners Mario M. Cuomo, *et al.*, at 11. Similarly, the AFL-CIO, as *amicus curiae* in support of petitioners, recognizes the impact of the assessments on plan administration and design: "Multi-state ERISA health plans must take these market differences from state to state into account in determining what kind of payment system to adopt or maintain." Brief for the American Federation of State County and Municipal Employees, AFL-CIO as *Amicus Curiae* in Support of Petitioners, at 14.

Petitioners attempt to minimize the assessment's effect as merely an indirect economic impact. Their arguments, however, ignore the fact that economics are inextricably linked to plan choices.[3] In addition, the characterization of the New York assessment law, on the whole, as the "indirect" regulation of health care plans is misleading in the specific context of the 9% assessment. As a preliminary matter, it is well settled that the singling out of ERISA plans through state action runs afoul of the preemption clause, regardless whether the impact is indirect or direct. *See Ingersoll-Rand*, 498 U.S. at 139 ("state law may 'relate to' a benefit plan . . . even if the law is not specifically designed to affect such plans, or the effect is only indirect"); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 47-48 (1986), *quoting Shaw*, 463 U.S. at 98 ("preemption clause is not limited to 'state laws specifically designed to affect employee benefit plans'"); *Alessi*, 451 U.S. at 525 ("even indirect state

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3. The important role played by economics in the design and structure of employee benefits has become even more evident from the reductions in employer sponsored benefits in recent years, many of which have resulted in the proliferation of costly and protracted litigation, such as that involving retiree health coverage. Moreover, the recent efforts to develop a national health care system and the debate that ensued over how such a program would be funded reinforced the importance of the role that costs play in defining the structure of health care benefit plans.

action bearing on private pension plans may encroach upon the area of exclusive federal concern").

Moreover, the impact of the 9% assessment on ERISA plans that select HMO coverage is "direct" because the assessment specifically is directed only at HMOs. This is not a law of general application, such as a utility rate or sales tax, which impacts equally all health care delivery systems. It is an assessment that, by its terms, singles out HMOs. Though the impact of a law of general application on one form of health care delivery system might be characterized as "indirect," the impact of a law premised on the disparate treatment of one health care delivery system, to the exclusion of others, such as the 9% assessment, is hardly indirect. It is directed at the cost of HMO coverage, and, therefore, its impact on HMO plans clearly is direct.[4]

Federal policy has been used by the Court as a touchstone to interpret the preemptive scope of ERISA. In *Mackey v. Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825 (1987), this Court held that a Georgia garnishment statute was not preempted by ERISA because, based on the statements of federal policy in ERISA's civil enforcement provisions and the "sue and be sued" clauses of other federal statutes, the Court concluded that Congress did not intend to preempt the state garnishment law. In discerning Congress' intent, the Court concluded that the Georgia law withstood the preemption challenge because it was consistent with these sources of federal policy. *Mackey*, 486 U.S. at 831-34 & n.9.

Applying the *Mackey* approach to New York's 9% assessment, it is clear that federal policy does not favor state interference with the competitive market choices of ERISA plans for health coverage. Just one year before

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4. If truly a law of general application, such as a state sales tax, the 9% assessment would affect equally all ERISA health care plans, regardless of their choice of delivery system. Thus, a state sales tax is not preempted by ERISA.

enacting ERISA in 1974, Congress passed the Federal HMO Act of 1973, 42 U.S.C. §§ 300e, *et seq.* (1987), declaring its intent that the states cease interfering with the development of HMOs as a desirable alternative to costly indemnity insurance in the health care coverage market. The Federal HMO Act is a pertinent source of federal policy that must be considered in determing the scope of the ERISA preemption of state laws regulating the health care coverage market for ERISA plans.

Cognizant of the historical treatment of HMOs by the states, Congress enacted a federal law designed to shield HMOs from unfair treatment by the states and to enable HMOs to develop and grow as an alternative to indemnity insurance. The federal policy reflected in the Federal HMO Act leaves little room for doubt that Congress recognized that state action directed at HMOs can have a detrimental and adverse impact on the competitive health care coverage market to which many ERISA plans look for the cost-effective coverage offered by HMOs. To read ERISA's preemption clause so narrowly to exclude state laws specifically directed at HMOs and intended to have an adverse economic impact on them would ignore entirely the federal policy contained in the HMO Act.

ERISA was intended to ensure that the employer's choice of delivery of a uniform health care coverage system across state lines would not be disrupted. 20 Cong. Rec. 29197 (1974) (remarks of Rep. Dent) (ERISA sponsors designed preemption clause to eliminate threat of inconsistent state and local regulations); *id.*, at 29933 (remarks of Sen. Williams) (same); *see also FMC Corp. v. Holliday*, 498 U.S. 52, 60 (1990) ("To require plan providers to design their programs in an environment of differing state regulations would complicate the administration of nationwide plans . . . ."); *Fort Halifax*, 482 U.S. at 11 (patchwork scheme of state regulation of ERISA benefit plans would introduce considerable inefficiencies in benefit program operation).

The economic impact of the 9% assessment has the effect, contrary to the intent of ERISA, of disrupting the uniform choices of plans sponsored by multi-state employers to provide health care coverage to their employees. When the states are permitted to engage in disparate economic treatment of one form of health care delivery system, as New York has done to HMOs under the 9% assessment, it affects the balance of incentives established by multi-state employers and interferes with the structure of the ERISA plan premised on that balance. Accordingly, the assessment interferes with the ability of multi-state employers to offer uniform health coverage to their employees, including the HMO plan.

The HMO approach is unique because HMOs provide high quality, comprehensive and preventive health care coverage at an affordable price. Indeed, HMO coverage frequently will be the lowest priced option for health care coverage. Thus, HMO coverage is attractive to a multi-state employer that sponsors a health care plan for its employees because such coverage offers comprehensive benefits to employees while simultaneously providing the employer with a health care delivery system that coordinates the care through a network of physicians, emphasizes the prevention of serious health problems, oversees appropriate standards of care and monitors the quality of the services rendered. Only an HMO offers this unique combination of features and benefits in one health care delivery system.

The multi-state employer relies upon the competitive price of HMO coverage, as compared to more costly indemnity insurance, to attract participants to the HMO plans offered in each state where employees are located. Moreover, where the employer uses its lowest-priced health care option, often an HMO, as the benchmark for its contribution to the cost of employee health care coverage, an employee's incentive to select HMO coverage is further enhanced insofar as it is the only health care option that will be fully paid by the employer. This incentive is reinforced because virtually all HMO plans

have no deductibles and nominal, if any, co-payments for covered services. In short, the more attractive the HMO plan is to employees, the more likely it is that they will select the HMO plan for their health coverage.

When employees select HMO coverage over more costly indemnity insurance, the multi-state employer sponsoring the plans also obtains the sought-after benefits of HMO coverage. The employer is the beneficiary of the HMO's philosophy of prevention and quality assurance mechanisms, which are superior to those available under indemnity insurance. The employer knows that its employees are receiving care through a coordinated network of medical professionals, that the quality of the care will be enhanced by the application of practice guidelines and standards and that the care will be subject to ongoing monitoring and improvement. Most significantly, the HMO coverage offers employees comprehensive benefits, including preventive services. All of these aspects of HMO care have the effect of lowering the overall cost of health care coverage while providing enhanced quality.

The 9% assessment disrupts this careful balance of incentives established by the employer sponsoring the HMO plan by appropriating the cost efficiency of HMO coverage. Such legislation erodes the cost effectiveness of the HMO plan, thereby frustrating the incentive that the multi-state employer established to encourage its employees, regardless of the state where they work, to enroll in the HMO. The loss of this incentive, in turn, reduces the likelihood that the employer will realize the benefits of the HMO plan, including the quality assurance and improvement mechanisms that are available only under that plan. Thus, the multi-state employer is deprived of the full pricing incentive to encourage HMO enrollment and of the benefits that flow from its choice to exercise that incentive.

When the states pass legislation that has the direct effect of appropriating the cost effectiveness of an HMO plan, they undermine both the incentive chosen by the

plan sponsor to encourage employee enrollment in the plan and the resulting benefits that flow from that choice – a comprehensive level of high quality benefits. If such laws are not preempted, the states would be free to divest dollar by dollar the choices made by plan sponsors to offer HMO coverage. ERISA, however, is intended to prevent the states from disrupting the design and structure of ERISA plans. The 9% assessment has just such a disruptive effect, and, therefore, it is has a "connection with" ERISA plans. For these reasons, the Second Circuit correctly held that the 9% assessment is preempted.[5]

5. Petitioners do not assert that the 9% assessment is a law regulating the business of insurance that is saved from preemption under ERISA's "insurance savings" clause, 29 U.S.C. § 1144(b)(2)(A) (1985). *See also* Brief of the United States as *Amicus Curiae* Supporting Petitioners, at 19 n.8 (no party argues that the 9% assessment is saved as a law regulating insurance). GHAA concurs that the 9% law is not saved from preemption.

CONCLUSION

For the foregoing reasons, the decision and judgment of the United States Court of Appeals for the Second Circuit in this case should be affirmed.

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